Western Medicine, Inc

Pediatric/Adolescent Medical History

Child's Name ________________________________ Nickname: _________________ DOB: _____________
Mother's Name ___________________________ Occupation: _______________ Phone # _______________
Father's Name ___________________________ Occupation: _______________ Phone # ________________
Are the child's parents ___ Married ___ Unmarried ___ Separated ___ Divorced
Are there any siblings at home? YES NO Please list ages: _____________________________________
This child lives with __ Mother & Father __ Mother Only __ Father Only __ Other: ___________________
Does your child attend daycare? ________ Primary language spoken at home__________________
Who takes care of the child during the day or after school? ____

Child's Health History

Birth weight? _____________ Please Circle : Term Pre Term Post Term

Is child adopted? YES NO
Complications with pregnancy? YES NO
Hospitalizations immediately after birth? YES NO
Has child missed any immunizations? YES NO
Has your child ever had surgery? YES NO
If yes, please list what types: ____

Other hospitalizations? YES NO
Any problems with recurring illnesses? YES NO
Any hearing, vision or other disabilities? YES NO
Any concerns about your child's development? YES NO
Any concerns with your child bedwetting? YES NO
Any concerns about your child's behavior? YES NO
Has your child ever been seen by a specialist? YES NO
If yes to any of the above questions, please explain ____
____
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Does your child have any ***ALLERGIES*** to any medications, foods, or other materials? YES NO
If yes, to what? ____

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*List all **medications** your child takes (include over the counter meds, vitamins and inhalers)*

NAME OF MEDICATION	STRENGTH	DIRECTIONS

FAMILY HISTORY

Does anyone in the family have any history of the following?
Please list: *mother, father, maternal / paternal grandmother / grandfather, sibling*
M P GM GF

High blood pressure	YES	NO	Who ____________________
High cholesterol	YES	NO	Who ____________________
Heart disease	YES	NO	Who ____________________
Stroke	YES	NO	Who ____________________
Diabetes	YES	NO	Who ____________________
Thyroid disease	YES	NO	Who ____________________
Cancer	YES	NO	Who ____________________
Bleeding/clotting disorder	YES	NO	Who ____________________
Allergies	YES	NO	Who ____________________
Asthma	YES	NO	Who ____________________
Liver disease	YES	NO	Who ____________________
Kidney disease	YES	NO	Who ____________________
Seizures	YES	NO	Who ____________________
Migraines	YES	NO	Who ____________________
Acid reflux	YES	NO	Who ____________________
Gastrointestinal disease	YES	NO	Who ____________________
Mental problems	YES	NO	Who ____________________
Alcohol problems	YES	NO	Who ____________________
Drug problems	YES	NO	Who ____________________
Genetic disorders/Birth defects	YES	NO	Who ____________________
Autism	YES	NO	Who ____________________

Safety/Prevention

Does your child wear a seat belt?	YES	NO	N/A
Does your child use a car seat?	YES	NO	N/A
Does your child sit in the back seat?	YES	NO	N/A
Does your child wear protective headgear during certain activities?	YES	NO	
Does your child receive regular dental care?	YES	NO	
Do you having working smoke detectors at home?	YES	NO	
Are there any firearms in the home?	YES	NO	
Is violence at home a concern?	YES	NO	
Is your child exposed to any second-hand smoke?	YES	NO	
Are there any pets at home?	YES	NO	

Do you have any other concerns about your child? ____
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